



General Assembly

Substitute Bill No. 1249

January Session, 2005

* SB01249FIN__050305__ *

AN ACT CONCERNING PREFERRED PROVIDER NETWORKS.

Be it enacted by the Senate and House of Representatives in General Assembly convened:

1 Section 1. Section 38a-479aa of the general statutes is repealed and
2 the following is substituted in lieu thereof (*Effective July 1, 2005*):

3 (a) As used in this part and subsection (b) of section 20-138b:

4 (1) "Covered benefits" means health care services to which an
5 enrollee is entitled under the terms of a managed care plan;

6 (2) "Enrollee" means an individual who is eligible to receive health
7 care services through a preferred provider network;

8 (3) "Health care services" means health care related services or
9 products rendered or sold by a provider within the scope of the
10 provider's license or legal authorization, and includes hospital,
11 medical, surgical, dental, vision and pharmaceutical services or
12 products;

13 (4) "Managed care organization" means (A) a managed care
14 organization, as defined in section 38a-478, (B) any other health
15 insurer, or (C) a reinsurer with respect to health insurance;

16 (5) "Managed care plan" means a managed care plan, as defined in
17 section 38a-478;

18 (6) "Person" means an individual, agency, political subdivision,
19 partnership, corporation, limited liability company, association or any
20 other entity;

21 (7) "Preferred provider network" means [a person, which is not a
22 managed care organization, but which pays claims for the delivery of
23 health care services, accepts financial risk for the delivery of health
24 care services and establishes, operates or maintains an arrangement or
25 contract with providers relating to (A) the health care services
26 rendered by the providers, and (B) the amounts to be paid to the
27 providers for such services] a person who establishes, operates,
28 maintains or is financially responsible for, in whole or in part, an
29 arrangement in which an agreement relating to the health care services
30 to be rendered by providers is entered into between such providers
31 and the person, and includes any provider-sponsored arrangement or
32 independent practice association that offers network services.
33 "Preferred provider network" also includes a risk-bearing preferred
34 provider network. "Preferred provider network" does not include a
35 workers' compensation preferred provider organization established
36 pursuant to section 31-279-10 of the regulations of Connecticut state
37 agencies; or an independent practice association or physician hospital
38 organization whose primary function is to contract with insurers and
39 provide services to providers;

40 (8) "Provider" means an individual or entity duly licensed or legally
41 authorized to provide health care services; [and]

42 (9) "Commissioner" means the Insurance Commissioner; and

43 (10) "Risk-bearing preferred provider network" means a person,
44 which is not a managed care organization, but which (A) establishes,
45 operates or maintains an arrangement or contract with providers
46 relating to (i) the health care services rendered by providers, and (ii)
47 the amounts to be paid to the providers for such services, and (B) uses
48 the funds of a licensed insurer or other third party to pay providers.

49 [(b) On and after May 1, 2004, no preferred provider network may
50 enter into or renew a contractual relationship with a managed care
51 organization unless the preferred provider network is licensed by the
52 commissioner. On and after May 1, 2005, no preferred provider
53 network may conduct business in this state unless it is licensed by the
54 commissioner. Any person seeking to obtain or renew a license shall
55 submit an application to the commissioner, on such form as the
56 commissioner may prescribe, and shall include the filing described in
57 this subsection, except that a person seeking to renew a license may
58 submit only the information necessary to update its previous filing.
59 Applications shall be submitted by March first of each year in order to
60 qualify for the May first license issue or renewal date.]

61 (b) Any preferred provider network that seeks to conduct business
62 in this state shall, prior to accepting enrollees, file the information
63 required in this subsection with the commissioner. Before each May
64 first thereafter, each preferred provider network that continues to do
65 business in this state and that has completed an initial filing shall file
66 with the commissioner the information necessary to update its
67 previous filing. The filing required from such preferred provider
68 network shall include the following information: (1) The identity of the
69 preferred provider network and any company or organization
70 controlling the operation of the preferred provider network, including
71 the name, business address, contact person, a description of the
72 controlling company or organization and, where applicable, the
73 following: (A) A certificate from the Secretary of the State regarding
74 the preferred provider network's and the controlling company's or
75 organization's good standing to do business in the state; (B) a copy of
76 the preferred provider network's and the controlling company's or
77 organization's financial statement completed in accordance with
78 sections 38a-53 and 38a-54, as applicable, for the end of its most
79 recently concluded fiscal year, along with the name and address of any
80 public accounting firm or internal accountant which prepared or
81 assisted in the preparation of such financial statement; (C) a list of the
82 names, official positions and occupations of members of the preferred

83 provider network's and the controlling company's or organization's
84 board of directors or other policy-making body and of those executive
85 officers who are responsible for the preferred provider network's and
86 controlling company's or organization's activities with respect to the
87 health care services network; (D) a list of the preferred provider
88 network's and the controlling company's or organization's principal
89 owners; (E) in the case of an out-of-state preferred provider network,
90 controlling company or organization, a certificate that such preferred
91 provider network, company or organization is in good standing in its
92 state of organization; (F) in the case of a Connecticut or out-of-state
93 preferred provider network, controlling company or organization, a
94 report of the details of any suspension, sanction or other disciplinary
95 action relating to such preferred provider network, or controlling
96 company or organization in this state or in any other state; and (G) the
97 identity, address and current relationship of any related or predecessor
98 controlling company or organization. For purposes of this
99 subparagraph, "related" means that a substantial number of the board
100 or policy-making body members, executive officers or principal
101 owners of both companies are the same; (2) a general description of the
102 preferred provider network and participation in the preferred provider
103 network, including: (A) The geographical service area of and the
104 names of the hospitals included in the preferred provider network; (B)
105 the primary care physicians, the specialty physicians, any other
106 contracting providers and the number and percentage of each group's
107 capacity to accept new patients; (C) a list of all entities on whose behalf
108 the preferred provider network has contracts or agreements to provide
109 health care services; (D) a table listing all major categories of health
110 care services provided by the preferred provider network; (E) an
111 approximate number of total enrollees served in all of the preferred
112 provider network's contracts or agreements; (F) a list of subcontractors
113 of the preferred provider network, not including individual
114 participating providers, that assume financial risk from the preferred
115 provider network and to what extent each subcontractor assumes
116 financial risk; and (G) [a contingency plan describing how contracted
117 health care services will be provided in the event of insolvency; and

118 (H)] any other information requested by the commissioner; and (3) the
119 name and address of the person to whom applications may be made
120 for participation.

121 (c) Any person developing a preferred provider network, or
122 expanding a preferred provider network into a new county, pursuant
123 to this section and subsection (b) of section 20-138b, shall publish a
124 notice, in at least one newspaper having a substantial circulation in the
125 service area in which the preferred provider network operates or will
126 operate, indicating such planned development or expansion. Such
127 notice shall include the medical specialties included in the preferred
128 provider network, the name and address of the person to whom
129 applications may be made for participation and a time frame for
130 making application. The preferred provider network shall provide the
131 applicant with written acknowledgment of receipt of the application.
132 Each complete application shall be considered by the preferred
133 provider network in a timely manner.

134 (d) (1) Each preferred provider network shall file with the
135 commissioner and make available upon request from a provider the
136 general criteria for its selection or termination of providers. Disclosure
137 shall not be required of criteria deemed by the preferred provider
138 network to be of a proprietary or competitive nature that would hurt
139 the preferred provider network's ability to compete or to manage
140 health care services. For purposes of this section, criteria is of a
141 proprietary or competitive nature if it has the tendency to cause
142 providers to alter their practice pattern in a manner that would
143 circumvent efforts to contain health care costs and criteria is of a
144 proprietary nature if revealing the criteria would cause the preferred
145 provider network's competitors to obtain valuable business
146 information.

147 (2) If a preferred provider network uses criteria that have not been
148 filed pursuant to subdivision (1) of this subsection to judge the quality
149 and cost-effectiveness of a provider's practice under any specific
150 program within the preferred provider network, the preferred

151 provider network may not reject or terminate the provider
152 participating in that program based upon such criteria until the
153 provider has been informed of the criteria that the provider's practice
154 fails to meet.

155 (e) Each preferred provider network shall permit the Insurance
156 Commissioner to inspect its books and records.

157 (f) Each preferred provider network shall permit the commissioner
158 to examine, under oath, any officer or agent of the preferred provider
159 network or controlling company or organization with respect to the
160 use of the funds of the preferred provider network, company or
161 organization, and compliance with (1) the provisions of this part, and
162 (2) the terms and conditions of its contracts to provide health care
163 services.

164 (g) Each preferred provider network shall file with the
165 commissioner a notice of any material modification of any matter or
166 document furnished pursuant to this part, and shall include such
167 supporting documents as are necessary to explain the modification.

168 [(h) Each preferred provider network shall maintain a minimum net
169 worth of either (1) the greater of (A) two hundred fifty thousand
170 dollars, or (B) an amount equal to eight per cent of its annual
171 expenditures as reported on its most recent financial statement
172 completed and filed with the commissioner in accordance with
173 sections 38a-53 and 38a-54, as applicable, or (2) another amount
174 determined by the commissioner.]

175 (h) No risk-bearing preferred provider network may conduct
176 business in this state unless it is licensed by the commissioner in
177 accordance with this section. Any person seeking to obtain or renew a
178 license as a risk-bearing preferred provider network shall submit an
179 application to the commissioner, on such form as the commissioner
180 may prescribe and shall include the filing described in subsection (a) of
181 this section and the filing fee set forth in section 38a-11, as amended by
182 this act, except that a person seeking to renew a license may submit

183 only the information necessary to update its previous filing.
184 Applications shall be submitted by March first of each year in order to
185 qualify for the May first license issue or renewal date.

186 (i) Each risk-bearing preferred provider network shall maintain or
187 arrange for a letter of credit, bond, surety, reinsurance, reserve or other
188 financial security acceptable to the commissioner for the exclusive use
189 of paying any outstanding amounts owed participating providers in
190 the event of insolvency or nonpayment except that any remaining
191 security may be used for the purpose of reimbursing managed care
192 organizations in accordance with subsection (b) of section 38a-479bb₂
193 as amended by this act. Such outstanding amount shall be at least an
194 amount equal to the greater of (1) an amount calculated on the basis of
195 the sum of two quarters within the past year with the greatest amounts
196 owed by the risk-bearing preferred provider network to participating
197 providers, (2) the actual outstanding amount owed by the risk-bearing
198 preferred provider network to participating providers, or (3) another
199 amount determined by the commissioner. [Such amount may be
200 credited against the preferred provider network's minimum net worth
201 requirements set forth in subsection (h) of this section.] The
202 commissioner shall review such security amount and calculation on a
203 quarterly basis.

204 (j) Each risk-bearing preferred provider network shall pay the
205 applicable license or renewal fee specified in section 38a-11, as
206 amended by this act. The commissioner shall use the amount of such
207 fees solely for the purpose of regulating preferred provider networks.

208 (k) In no event, including, but not limited to, nonpayment by the
209 managed care organization, insolvency of the managed care
210 organization, or breach of contract between the managed care
211 organization and the preferred provider network, shall a preferred
212 provider network bill, charge, collect a deposit from, seek
213 compensation, remuneration or reimbursement from, or have any
214 recourse against an enrollee or an enrollee's designee, other than the
215 managed care organization, for covered benefits provided, except that

216 the preferred provider network may collect any copayments,
217 deductibles or other out-of-pocket expenses that the enrollee is
218 required to pay pursuant to the managed care plan.

219 (l) Each contract or agreement between a preferred provider
220 network and a participating provider shall contain a provision that if
221 the preferred provider network fails to pay for health care services as
222 set forth in the contract, the enrollee shall not be liable to the
223 participating provider for any sums owed by the preferred provider
224 network or any sums owed by the managed care organization because
225 of nonpayment by the managed care organization, insolvency of the
226 managed care organization or breach of contract between the managed
227 care organization and the preferred provider network.

228 (m) Each utilization review determination made by or on behalf of a
229 preferred provider network shall be made in accordance with sections
230 38a-226 to 38a-226d, inclusive, except that any initial appeal of a
231 determination not to certify an admission, service, procedure or
232 extension of stay shall be conducted in accordance with subdivision (7)
233 of subsection (a) of section 38a-226c, and any subsequent appeal shall
234 be referred to the managed care organization on whose behalf the
235 preferred provider network provides services. The managed care
236 organization shall conduct the subsequent appeal in accordance with
237 said subdivision.

238 (n) Each risk-bearing preferred provider network shall establish a
239 contingency plan describing how contracted health care services will
240 be provided in the event of insolvency.

241 Sec. 2. Section 38a-479bb of the general statutes is repealed and the
242 following is substituted in lieu thereof (*Effective July 1, 2005*):

243 (a) On and after May 1, 2004, no managed care organization may
244 enter into or renew a contractual relationship with a risk-bearing
245 preferred provider network that is not licensed in accordance with
246 section 38a-479aa, as amended by this act. On and after May 1, 2005, no
247 managed care organization may continue or maintain a contractual

248 relationship with a risk-bearing preferred provider network that is not
249 licensed in accordance with section 38a-479aa, as amended by this act.

250 (b) Each managed care organization that contracts with a risk-
251 bearing preferred provider network shall (1) post and maintain or
252 require the risk-bearing preferred provider network to post and
253 maintain a letter of credit, bond, surety, reinsurance, reserve or other
254 financial security acceptable to the Insurance Commissioner, in order
255 to satisfy the risk accepted by the risk-bearing preferred provider
256 network pursuant to the contract, in an amount calculated in
257 accordance with subsection (i) of section 38a-479aa, as amended by this
258 act, and (2) determine who posts and maintains the security required
259 under subdivision (1) of this subsection. In the event of insolvency or
260 nonpayment such security shall be used by the risk-bearing preferred
261 provider network, or other entity designated by the commissioner,
262 solely for the purpose of paying any outstanding amounts owed
263 participating providers, except that any remaining security may be
264 used for the purpose of reimbursing the managed care organization for
265 any payments made by the managed care organization to participating
266 providers on behalf of the risk-bearing preferred provider network.

267 (c) Each managed care organization that contracts with a risk-
268 bearing preferred provider network shall provide to the risk-bearing
269 preferred provider network at the time the contract is entered into and
270 annually thereafter:

271 (1) Information, as determined by the managed care organization,
272 regarding the amount and method of remuneration to be paid to the
273 risk-bearing preferred provider network;

274 (2) Information, as determined by the managed care organization, to
275 assist the risk-bearing preferred provider network in being informed
276 regarding any financial risk assumed under the contract or agreement,
277 including, but not limited to, enrollment data, primary care provider to
278 covered person ratios, provider to covered person ratios by specialty, a
279 table of the services that the risk-bearing preferred provider network is

280 responsible for, expected or projected utilization rates, and all factors
281 used to adjust payments or risk-sharing targets;

282 (3) The National Associations of Insurance Commissioners annual
283 statement for the managed care organization; and

284 (4) Any other information the commissioner may require.

285 (d) Each managed care organization shall ensure that any contract it
286 has with a preferred provider network or risk-bearing preferred
287 provider network, as the case may be, includes:

288 (1) A provision that requires the preferred provider network or the
289 risk-bearing preferred provider network, as the case may be, to
290 provide to the managed care organization at the time a contract is
291 entered into, annually, and upon request of the managed care
292 organization, (A) with respect to a risk-bearing preferred provider
293 network, the financial statement completed in accordance with
294 sections 38a-53 and 38a-54, as applicable, and section 38a-479aa, as
295 amended by this act; (B) with respect to a risk-bearing preferred
296 provider network, documentation that satisfies the managed care
297 organization that the risk-bearing preferred provider network has
298 sufficient ability to accept financial risk; (C) with respect to a risk-
299 bearing preferred provider network, documentation that satisfies the
300 managed care organization that the risk-bearing preferred provider
301 network has appropriate management expertise and infrastructure; (D)
302 with respect to all preferred provider networks, documentation that
303 satisfies the managed care organization that the preferred provider
304 network has an adequate provider network taking into account the
305 geographic distribution of enrollees and participating providers and
306 whether participating providers are accepting new patients; (E) with
307 respect to all preferred provider networks, an accurate list of
308 participating providers; and (F) with respect to all preferred provider
309 networks, documentation that satisfies the managed care organization
310 that the preferred provider network has the ability to ensure the
311 delivery of health care services as set forth in the contract;

312 (2) A provision that requires the risk-bearing preferred provider
313 network to provide to the managed care organization a quarterly
314 status report that includes (A) information updating the financial
315 statement completed in accordance with sections 38a-53 and 38a-54, as
316 applicable, and section 38a-479aa, as amended by this act; (B) a report
317 showing amounts paid to those providers who provide health care
318 services on behalf of the managed care organization; (C) an estimate of
319 payments due providers but not yet reported by providers; (D)
320 amounts owed to providers for that quarter; and (E) the number of
321 utilization review determinations not to certify an admission, service,
322 procedure or extension of stay made by or on behalf of the risk-bearing
323 preferred provider network and the outcome of such determination on
324 appeal;

325 (3) A provision that requires the risk-bearing preferred provider
326 network to provide notice to the managed care organization not later
327 than five business days after (A) any change involving the ownership
328 structure of the risk-bearing preferred provider network; (B) financial
329 or operational concerns arise regarding the financial viability of the
330 risk-bearing preferred provider network; or (C) the risk-bearing
331 preferred provider network's loss of a license in this or any other state;

332 (4) A provision that if the managed care organization fails to pay for
333 health care services as set forth in the contract, the enrollee will not be
334 liable to the provider or risk-bearing preferred provider network for
335 any sums owed by the managed care organization or risk-bearing
336 preferred provider network;

337 (5) A provision that the risk-bearing preferred provider network
338 shall include in all contracts between the risk-bearing preferred
339 provider network and participating providers a provision that if the
340 risk-bearing preferred provider network fails to pay for health care
341 services as set forth in the contract, for any reason, the enrollee shall
342 not be liable to the participating provider or risk-bearing preferred
343 provider network for any sums owed by the risk-bearing preferred
344 provider network or any sums owed by the managed care

345 organization because of nonpayment by the managed care
346 organization, insolvency of the managed care organization or breach of
347 contract between the managed care organization and the risk-bearing
348 preferred provider network;

349 (6) A provision requiring the risk-bearing preferred provider
350 network to provide information to the managed care organization,
351 satisfactory to the managed care organization, regarding the risk-
352 bearing preferred provider network's reserves for financial risk;

353 (7) A provision that (A) the risk-bearing preferred provider network
354 or managed care organization shall post and maintain a letter of credit,
355 bond, surety, reinsurance, reserve or other financial security acceptable
356 to the commissioner, in order to satisfy the risk accepted by the risk-
357 bearing preferred provider network pursuant to the contract, in an
358 amount calculated in accordance with subsection (i) of section 38a-
359 479aa, as amended by this act, (B) the managed care organization shall
360 determine who posts and maintains the security required under
361 subparagraph (A) of this subdivision, and (C) in the event of
362 insolvency or nonpayment, such security shall be used by the risk-
363 bearing preferred provider network, or other entity designated by the
364 commissioner, solely for the purpose of paying any outstanding
365 amounts owed participating providers, except that any remaining
366 security may be used for the purpose of reimbursing the managed care
367 organization for any payments made by the managed care
368 organization to participating providers on behalf of the risk-bearing
369 preferred provider network;

370 (8) A provision under which the managed care organization is
371 permitted, at the discretion of the managed care organization, to pay
372 participating providers directly and in lieu of the risk-bearing
373 preferred provider network in the event of insolvency or
374 mismanagement by the risk-bearing preferred provider network and
375 that payments made pursuant to this subdivision may be made or
376 reimbursed from the security posted pursuant to subsection (b) of this
377 section;

378 (9) A provision transferring and assigning contracts between the
379 risk-bearing preferred provider network and participating providers to
380 the managed care organization for the provision of future services by
381 participating providers to enrollees, at the discretion of the managed
382 care organization, in the event the risk-bearing preferred provider
383 network (A) becomes insolvent, (B) otherwise ceases to conduct
384 business, as determined by the commissioner, or (C) demonstrates a
385 pattern of nonpayment of authorized claims, as determined by the
386 commissioner, for a period in excess of ninety days;

387 (10) A provision that each contract or agreement between the risk-
388 bearing preferred provider network and participating providers shall
389 include a provision transferring and assigning contracts between the
390 risk-bearing preferred provider network and participating providers to
391 the managed care organization for the provision of future health care
392 services by participating providers to enrollees, at the discretion of the
393 managed care organization, in the event the risk-bearing preferred
394 provider network (A) becomes insolvent, (B) otherwise ceases to
395 conduct business, as determined by the commissioner, or (C)
396 demonstrates a pattern of nonpayment of authorized claims, as
397 determined by the commissioner, for a period in excess of ninety days;

398 (11) A provision that the risk-bearing preferred provider network
399 shall pay for the delivery of health care services and operate or
400 maintain arrangements or contracts with providers in a manner
401 consistent with the provisions of law that apply to the managed care
402 organization's contracts with enrollees and providers; and

403 (12) A provision that the preferred provider network shall ensure
404 that utilization review determinations are made in accordance with
405 sections 38a-226 to 38a-226d, inclusive, except that any initial appeal of
406 a determination not to certify an admission, service, procedure or
407 extension of stay shall be made in accordance with subdivision (7) of
408 subsection (a) of section 38a-226c. In cases where an appeal to reverse a
409 determination not to certify is unsuccessful, the preferred provider
410 network shall refer the case to the managed care organization which

411 shall conduct the subsequent appeal, if any, in accordance with said
412 subdivision.

413 (e) Each managed care organization that contracts with a preferred
414 provider network shall have adequate procedures in place to notify the
415 commissioner that a preferred provider network has experienced an
416 event that may threaten the preferred provider network's ability to
417 materially perform under its contract with the managed care
418 organization. The managed care organization shall provide such notice
419 to the commissioner not later than five days after it discovers that the
420 preferred provider network has experienced such an event.

421 (f) Each managed care organization that contracts with a risk-
422 bearing preferred provider network shall monitor and maintain
423 systems and controls for monitoring the financial health of the risk-
424 bearing preferred provider networks with which it contracts.

425 (g) Each managed care organization that contracts with a risk-
426 bearing preferred provider network shall provide to the commissioner,
427 and update on an annual basis, a contingency plan, satisfactory to the
428 commissioner, describing how health care services will be provided to
429 enrollees if the risk-bearing preferred provider network becomes
430 insolvent or is mismanaged. The contingency plan shall include a
431 description of what contractual and financial steps have been taken to
432 ensure continuity of care to enrollees if the risk-bearing preferred
433 provider network becomes insolvent or is mismanaged.

434 (h) Notwithstanding any agreement to the contrary, each managed
435 care organization shall retain full responsibility to its enrollees for
436 providing coverage for health care services pursuant to any applicable
437 managed care plan and any applicable state or federal law. Each
438 managed care organization shall exercise due diligence in its selection
439 and oversight of a preferred provider network.

440 (i) Notwithstanding any agreement to the contrary, each managed
441 care organization shall be able to demonstrate to the satisfaction of the
442 commissioner that the managed care organization can fulfill its

443 nontransferable obligations to provide coverage for the provision of
444 health care services to enrollees in the event of the failure, for any
445 reason, of a preferred provider network.

446 (j) Each managed care organization that contracts with a preferred
447 provider network shall provide that in the event of the failure, for any
448 reason, of a preferred provider network, the managed care
449 organization shall provide coverage for the enrollee to continue
450 covered treatment with the provider who treated the enrollee under
451 the preferred provider network contract regardless of whether the
452 provider participates in any plan operated by the managed care
453 organization. In the event of such failure, the managed care
454 organization shall continue coverage until the earlier of (1) the date the
455 enrollee's treatment is completed under a treatment plan that was
456 authorized and in effect on the date of the failure, or (2) the date the
457 contract between the enrollee and the managed care organization
458 terminates. [The] In the event of the failure of a risk-bearing preferred
459 provider network, the managed care organization shall compensate a
460 provider for such continued treatment at the rate due the provider
461 under the provider's contract with the failed risk-bearing preferred
462 provider network.

463 (k) Each managed care organization that contracts with a risk-
464 bearing preferred provider network shall confirm the information in
465 the quarterly status report submitted by the risk-bearing preferred
466 provider network pursuant to subdivision (2) of subsection (d) of this
467 section and shall submit such information to the commissioner, on
468 such form as the commissioner prescribes, not later than ten days after
469 receiving a request from the commissioner for such information.

470 (l) (1) Each managed care organization that contracts with a
471 preferred provider network shall certify annually to the commissioner,
472 on such form and in such manner as the commissioner prescribes, that
473 the managed care organization has reviewed the documentation
474 submitted by the preferred provider network pursuant to subdivision
475 (l) of subsection (d) of this section and has determined that the

476 preferred provider network maintains a provider network that is
477 adequate to ensure the delivery of health care services as set forth in
478 the contract. If the commissioner finds that the certification was not
479 submitted in good faith, the commissioner may deem the managed
480 care organization to have not complied with this subsection and may
481 take action pursuant to section 38a-479ee, as amended by this act.

482 (2) If the managed care organization determines that the preferred
483 provider network's provider network is not adequate and must be
484 increased, the managed care organization shall provide written notice
485 of the determination to the commissioner. Such notice shall describe
486 [(1)] (A) any plan in place for the preferred provider network to
487 increase its provider network, and [(2)] (B) the managed care
488 organization's contingency plan in the event the preferred provider
489 network does not satisfactorily increase its provider network.

490 (m) Nothing in this part or part 1a of this chapter shall be construed
491 to require a preferred provider network to share proprietary
492 information with a managed care organization concerning contracts or
493 financial arrangements with providers who are not included in that
494 managed care organization's network, or other preferred provider
495 networks or managed care organizations.

496 Sec. 3. Section 38a-479cc of the general statutes is repealed and the
497 following is substituted in lieu thereof (*Effective July 1, 2005*):

498 (a) Whenever a preferred provider network is providing services
499 pursuant to a contract with a managed care organization, the preferred
500 provider network may not establish any terms, conditions or
501 requirements for access, diagnosis or treatment that are different than
502 the terms, conditions or requirements for access, diagnosis or
503 treatment in the managed care organization's plan, except that no
504 preferred provider network shall be required to provide an enrollee
505 access to a provider who does not participate in the preferred provider
506 network unless the preferred provider network is required to provide
507 such access under its contract with the managed care organization.

508 (b) Whenever a risk-bearing preferred provider network is
509 providing services pursuant to a contract with a managed care
510 organization, the risk-bearing preferred provider network shall pay for
511 the delivery of health care services and operate and maintain
512 arrangements or contracts with providers in a manner consistent with
513 the provisions of law that apply to the managed care organization's
514 contracts with enrollees and providers.

515 Sec. 4. Section 38a-479dd of the general statutes is repealed and the
516 following is substituted in lieu thereof (*Effective July 1, 2005*):

517 Each risk-bearing preferred provider network shall examine its
518 outstanding amounts in each quarter and if the risk-bearing preferred
519 provider network determines that the outstanding amounts in a
520 quarter will exceed ninety-five per cent of the security posted pursuant
521 to subsection (i) of section 38a-479aa, as amended by this act, the risk-
522 bearing preferred provider network shall mail a notice to each of its
523 participating providers concerning the status of incurred claims and
524 shall send notice to each managed care organization with which it
525 contracts and the Insurance Commissioner on such form as the
526 commissioner prescribes. The commissioner shall meet with the
527 applicable managed care organization and risk-bearing preferred
528 provider network to ensure continued services to enrollees and
529 payment to providers.

530 Sec. 5. Section 38a-479ee of the general statutes is repealed and the
531 following is substituted in lieu thereof (*Effective July 1, 2005*):

532 (a) If the Insurance Commissioner determines that a risk-bearing
533 preferred provider network or managed care organization, or both, has
534 not complied with any applicable provision of this part, sections 38a-
535 226 to 38a-226d, inclusive, or sections 38a-815 to 38a-819, inclusive, the
536 commissioner may (1) order the risk-bearing preferred provider
537 network or managed care organization, or both if both have not
538 complied, to cease and desist all operations in violation of this part or
539 said sections; (2) terminate or suspend the risk-bearing preferred

540 provider network's license; (3) institute a corrective action against the
541 risk-bearing preferred provider network or managed care
542 organization, or both if both have not complied; (4) order the payment
543 of a civil penalty by the risk-bearing preferred provider network or
544 managed care organization, or both if both have not complied, of not
545 more than one thousand dollars for each and every act or violation; (5)
546 order the payment of such reasonable expenses as may be necessary to
547 compensate the commissioner in conjunction with any proceedings
548 held to investigate or enforce violations of this part, sections 38a-226 to
549 38a-226d, inclusive, or sections 38a-815 to 38a-819, inclusive; and (6)
550 use any of the commissioner's other enforcement powers to obtain
551 compliance with this part, sections 38a-226 to 38a-226d, inclusive, or
552 sections 38a-815 to 38a-819, inclusive. The commissioner may hold a
553 hearing concerning any matter governed by this part, sections 38a-226
554 to 38a-226d, inclusive, or sections 38a-815 to 38a-819, inclusive, in
555 accordance with section 38a-16. Subject to the same confidentiality and
556 liability protections set forth in subsections (c) and (k) of section 38a-
557 14, the commissioner may engage the services of attorneys, appraisers,
558 independent actuaries, independent certified public accountants or
559 other professionals and specialists to assist the commissioner in
560 conducting an investigation under this section, the cost of which shall
561 be borne by the managed care organization or risk-bearing preferred
562 provider network, or both, that is the subject of the investigation.

563 (b) If a risk-bearing preferred provider network fails to comply with
564 any applicable provision of this part, sections 38a-226 to 38a-226d,
565 inclusive, or sections 38a-815 to 38a-819, inclusive, the commissioner
566 may assign or require the risk-bearing preferred provider network to
567 assign its rights and obligations under any contract with participating
568 providers in order to ensure that covered benefits are provided.

569 (c) The commissioner shall receive and investigate (1) any grievance
570 filed against a risk-bearing preferred provider network or managed
571 care organization, or both, by an enrollee or an enrollee's designee
572 concerning matters governed by this part, sections 38a-226 to 38a-226d,
573 inclusive, or sections 38a-815 to 38a-819, inclusive, or (2) any referral

574 from the Office of Managed Care Ombudsman pursuant to section
575 38a-1041. The commissioner shall code, track and review such
576 grievances and referrals. The risk-bearing preferred provider network
577 or managed care organization, or both, shall provide the commissioner
578 with all information necessary for the commissioner to investigate
579 such grievances and referrals. The information collected by the
580 commissioner pursuant to this section shall be maintained as
581 confidential and shall not be disclosed to any person except (A) to the
582 extent necessary to carry out the purposes of this part, sections 38a-226
583 to 38a-226d, inclusive, or sections 38a-815 to 38a-819, inclusive, (B) as
584 allowed under this title, (C) to the Managed Care Ombudsman, and
585 (D) information concerning the nature of any grievance or referral and
586 the commissioner's final determination shall be a public record, as
587 defined in section 1-200, provided no personal information, as defined
588 in section 38a-975, shall be disclosed. The commissioner shall report to
589 the Managed Care Ombudsman on the resolution of any matter
590 referred to the commissioner by the Managed Care Ombudsman.

591 Sec. 6. Subsection (a) of section 38a-11 of the general statutes is
592 repealed and the following is substituted in lieu thereof (*Effective July*
593 *1, 2005*):

594 (a) The commissioner shall demand and receive the following fees:
595 (1) For the annual fee for each license issued to a domestic insurance
596 company, one hundred dollars; (2) for receiving and filing annual
597 reports of domestic insurance companies, twenty-five dollars; (3) for
598 filing all documents prerequisite to the issuance of a license to an
599 insurance company, one hundred seventy-five dollars, except that the
600 fee for such filings by any health care center, as defined in section 38a-
601 175, shall be one thousand one hundred dollars; (4) for filing any
602 additional paper required by law, fifteen dollars; (5) for each certificate
603 of valuation, organization, reciprocity or compliance, twenty dollars;
604 (6) for each certified copy of a license to a company, twenty dollars; (7)
605 for each certified copy of a report or certificate of condition of a
606 company to be filed in any other state, twenty dollars; (8) for
607 amending a certificate of authority, one hundred dollars; (9) for each

608 license issued to a rating organization, one hundred dollars. In
609 addition, insurance companies shall pay any fees imposed under
610 section 12-211; (10) a filing fee of twenty-five dollars for each initial
611 application for a license made pursuant to section 38a-769; (11) with
612 respect to insurance agents' appointments: (A) A filing fee of twenty-
613 five dollars for each request for any agent appointment; (B) a fee of
614 forty dollars for each appointment issued to an agent of a domestic
615 insurance company or for each appointment continued; and (C) a fee
616 of twenty dollars for each appointment issued to an agent of any other
617 insurance company or for each appointment continued, except that no
618 fee shall be payable for an appointment issued to an agent of an
619 insurance company domiciled in a state or foreign country which does
620 not require any fee for an appointment issued to an agent of a
621 Connecticut insurance company; (12) with respect to insurance
622 producers: (A) An examination fee of seven dollars for each
623 examination taken, except when a testing service is used, the testing
624 service shall pay a fee of seven dollars to the commissioner for each
625 examination taken by an applicant; (B) a fee of forty dollars for each
626 license issued; and (C) a fee of forty dollars for each license renewed;
627 (13) with respect to public adjusters: (A) An examination fee of seven
628 dollars for each examination taken, except when a testing service is
629 used, the testing service shall pay a fee of seven dollars to the
630 commissioner for each examination taken by an applicant; and (B) a fee
631 of one hundred twenty-five dollars for each license issued or renewed;
632 (14) with respect to casualty adjusters: (A) An examination fee of ten
633 dollars for each examination taken, except when a testing service is
634 used, the testing service shall pay a fee of ten dollars to the
635 commissioner for each examination taken by an applicant; (B) a fee of
636 forty dollars for each license issued or renewed; and (C) the expense of
637 any examination administered outside the state shall be the
638 responsibility of the entity making the request and such entity shall
639 pay to the commissioner one hundred dollars for such examination
640 and the actual traveling expenses of the examination administrator to
641 administer such examination; (15) with respect to motor vehicle
642 physical damage appraisers: (A) An examination fee of forty dollars

643 for each examination taken, except when a testing service is used, the
644 testing service shall pay a fee of forty dollars to the commissioner for
645 each examination taken by an applicant; (B) a fee of forty dollars for
646 each license issued or renewed; and (C) the expense of any
647 examination administered outside the state shall be the responsibility
648 of the entity making the request and such entity shall pay to the
649 commissioner one hundred dollars for such examination and the
650 actual traveling expenses of the examination administrator to
651 administer such examination; (16) with respect to certified insurance
652 consultants: (A) An examination fee of thirteen dollars for each
653 examination taken, except when a testing service is used, the testing
654 service shall pay a fee of thirteen dollars to the commissioner for each
655 examination taken by an applicant; (B) a fee of two hundred dollars for
656 each license issued; and (C) a fee of one hundred twenty-five dollars
657 for each license renewed; (17) with respect to surplus lines brokers: (A)
658 An examination fee of ten dollars for each examination taken, except
659 when a testing service is used, the testing service shall pay a fee of ten
660 dollars to the commissioner for each examination taken by an
661 applicant; and (B) a fee of five hundred dollars for each license issued
662 or renewed; (18) with respect to fraternal agents, a fee of forty dollars
663 for each license issued or renewed; (19) a fee of thirteen dollars for
664 each license certificate requested, whether or not a license has been
665 issued; (20) with respect to domestic and foreign benefit societies shall
666 pay: (A) For service of process, twenty-five dollars for each person or
667 insurer to be served; (B) for filing a certified copy of its charter or
668 articles of association, five dollars; (C) for filing the annual report, ten
669 dollars; and (D) for filing any additional paper required by law, three
670 dollars; (21) with respect to foreign benefit societies: (A) For each
671 certificate of organization or compliance, four dollars; (B) for each
672 certified copy of permit, two dollars; and (C) for each copy of a report
673 or certificate of condition of a society to be filed in any other state, four
674 dollars; (22) with respect to reinsurance intermediaries: A fee of five
675 hundred dollars for each license issued or renewed; (23) with respect
676 to viatical settlement providers: (A) A filing fee of thirteen dollars for
677 each initial application for a license made pursuant to section 38a-465a;

678 and (B) a fee of twenty dollars for each license issued or renewed; (24)
 679 with respect to viatical settlement brokers: (A) A filing fee of thirteen
 680 dollars for each initial application for a license made pursuant to
 681 section 38a-465a; and (B) a fee of twenty dollars for each license issued
 682 or renewed; (25) with respect to viatical settlement investment agents:
 683 (A) A filing fee of thirteen dollars for each initial application for a
 684 license made pursuant to section 38a-465a; and (B) a fee of twenty
 685 dollars for each license issued or renewed; (26) with respect to risk-
 686 bearing preferred provider networks, a fee of two thousand five
 687 hundred dollars for each license issued or renewed; (27) with respect
 688 to rental companies, as defined in section 38a-799, a fee of forty dollars
 689 for each permit issued or renewed; and (28) with respect to each
 690 duplicate license issued a fee of twenty-five dollars for each license
 691 issued.

This act shall take effect as follows and shall amend the following sections:

Section 1	<i>July 1, 2005</i>	38a-479aa
Sec. 2	<i>July 1, 2005</i>	38a-479bb
Sec. 3	<i>July 1, 2005</i>	38a-479cc
Sec. 4	<i>July 1, 2005</i>	38a-479dd
Sec. 5	<i>July 1, 2005</i>	38a-479ee
Sec. 6	<i>July 1, 2005</i>	38a-11(a)

INS *Joint Favorable Subst.*

FIN *Joint Favorable*